Dignity Health
Woodland Healthcare

Woodland Memorial Hospital

2022 Community Health Needs Assessment – Main Report

Acknowledgements

We are deeply grateful to all those who contributed to the community health needs assessment conducted on behalf of Yolo County. Many dedicated community health experts and members of various social service organizations working with the most vulnerable members of the community gave their time and expertise as key informants and survey respondents to help guide and inform the findings of the assessment. Specific survey respondents that expressed a desire to be recognized in the report are listed in the technical section in the Service Provider Survey section. Many community residents also contributed as interview and Community Health Status Survey (community survey) participants and shared the challenges they face working to achieve better health. We also appreciate the collaborative spirit of Kaiser Permanente and their willingness to share the information they gathered while conducting a similar health assessment in the Sacramento area. To everyone who supported this important work, we extend our heartfelt gratitude.

Community Health Insights (www.communityhealthinsights.com) conducted the assessment on behalf of Yolo County. Community Health Insights is a Sacramento-based, research-oriented consulting firm dedicated to improving the health and well-being of communities across Central and Northern California. This joint report was authored by:

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Data and Technical Section of the report can be found online at https://www.dignityhealth.org/sacramento/about-us/community-health-and-outreach/health-needs-assessment.

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Report Summary

Purpose

The purpose of this community health needs assessment (CHNA) was to identify and prioritize significant health needs of the Yolo County (Yolo) community. The priorities identified in this report help to guide health improvement efforts of Woodland Memorial Hospital, Sutter Davis Hospital, and Yolo County Health and Human Services, Community Health Branch.

This report meets requirements of the Patient Protection and Affordable Care Act (and, in California, Senate Bill 697) that not-for-profit hospitals conduct a CHNA at least once every three years, as well as the Public Health Accreditation Board (PHAB) CHA requirements. The CHNA was conducted by Community Health Insights (www.communityhealthinsights.com). Multiple other community partners participated in and collaborated to conduct the health assessment, including CommuniCare Health Centers and Winters Healthcare.

Dignity Health Commitment and Mission Statement

The hospitals' dedication to engagement with the community, assessing priority needs, and helping to address them with community health program activities is in keeping with our mission. As part of CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Community Definition

Yolo County was chosen as the geographical area for the CHNA because it is the primary service area of the two hospitals participating in the joint assessment and is the statutory service area of the public health department. Yolo County is located northwest of Sacramento along the Interstate 5 corridor and includes both urban and rural communities. The City of Woodland is the county seat of Yolo County. Zip codes represented in the report include: 95605, 95606, 95607, 95612, 95616, 95618, 95620, 95627, 95637, 95645, 95653, 95679, 95691, 95694, 95695, 95697, 95698, 95776, and 95937.

Assessment Process and Methods

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model.[1] This model of population health includes many factors that impact and account for individual health and well-being. Furthermore, to guide the overall process of conducting the assessment, a defined set of data collection and analytic stages were developed. These included the collection and analysis of both primary (qualitative) and secondary (quantitative) data. Qualitative data included one-on-one and group interviews with 29 community health experts, members of the county's department of public health, social service providers, and medical personnel. Additionally, 18 community residents or community service provider organizations participated in 3 focus groups across the county. Finally, 14 community service providers responded to a Service Provider Survey asking about health need identification and prioritization and 1,574 community residents participated in the Community Health Status Survey (community survey).

Focusing on social determinants of health to identify and organize secondary data, datasets included measures to describe mortality and morbidity, as well as social and economic factors such as income, educational attainment, and employment. Furthermore, the measures also included indicators to describe health behaviors, clinical care (both quality and access), and the physical environment.

[1] County Health Rankings Model, Robert Wood Johnson Foundation, and University of Wisconsin, 2021. Retrieved from: http://www.countyhealthrankings.org/.

At the time that this assessment was conducted, the COVID-19 pandemic was still impacting communities across the United States, including Yolo County. The process for conducting the assessment remained fundamentally the same. However, adjustments were made during the qualitative data collection to ensure the health and safety of those participating. Additionally, COVID-19 data were incorporated into the quantitative data analysis and COVID-19 impact was captured during primary data collection as well. These findings are reported throughout various sections of the report.

Process and Criteria to Identify and Prioritize Significant Health Needs

Primary and secondary data were analyzed to identify and prioritize significant health needs. This began by identifying 12 potential health needs (PHNs). These PHNs were identified in previously conducted CHNAs. Data were analyzed to discover which, if any, of the PHNs were present in Yolo County. After these were identified, PHNs were labeled as significant health needs (SHNs) and were prioritized based on rankings provided by primary data sources. Data were also analyzed to detect emerging health needs beyond those 12 PHNs identified in previous CHNAs.

List of Prioritized Significant Health Needs

The following significant health needs identified for Yolo County are listed below in prioritized order.

1. Access to Basic Needs Such as Housing, Jobs, and Food
2. Access to Mental/Behavioral Health and Substance Use Services
3. Injury and Disease Prevention and Management
4. Active Living and Healthy Eating
5. Access to Quality Primary Care Health Services
6. System Navigation
7. Access to Specialty and Extended Care
8. Increased Community Connections
9. Safe and Violence-Free Environment
10. Access to Functional Needs
11. Access to Dental Care and Preventive Services

Communities of Concern

Communities of Concern are geographic areas within the county that have the greatest concentration of poor health outcomes and are home to more medically underserved, low-income, and diverse populations at greater risk for poorer health. Nine ZIP codes were identified as Communities of Concern for Yolo County and were separated into primary and secondary. The primary Communities of Concern included 95605 and 95691 (West Sacramento) and 95695 and 95776 (Woodland). Secondary Communities of Concern with low population size included 95612 (Clarksburg), 95627 (Esparto), 95645 (Knights Landing), 95653 (Madison), and 95937 (Dunnigan). According to 2019 American Community Survey 5-year estimates, the total population of the Communities of Concern was 127,497, which is 58.7% of Yolo County.

Resources Potentially Available to Meet the Significant Health Needs

In all, 367 resources were identified in the county that are potentially available to meet the identified significant health needs. The identification method included starting with the list of resources from the 2019 CHNA for Yolo County, verifying that the resources still existed, and then adding newly identified resources into the 2022 CHNA report.

Conclusion

This CHNA details the process and findings of a comprehensive health assessment to guide decision-making for the implementation of community health improvement efforts using a health equity lens. The CHNA includes an overall health and social examination of Yolo County and highlights the needs of community members living in parts of the county where more health disparities exist. This report also serves as a resource for community organizations in an effort to help improve the health and well-being of the communities they serve.

Report Adoption, Availability and Comments

The Community Board voted, approved and adopted the Community Health Needs Assessment for Woodland Memorial Hospital on May 31, 2022.

This main report and the data and technical section is widely available to the public on the hospital's web site (https://www.dignityhealth.org/sacramento/about-us/community-health-and-outreach/health-needs-assessment), and a paper copy is available for inspection upon request at Dignity Health, Community Health and Outreach Department, 3400 Data Drive, Rancho Cordova, CA 95670.

Written comments on this report can be submitted by email to DignityHealthGSSA_CHNA@dignityhealth.org

Introduction and Purpose

It is vital that health prevention efforts focus on the most critical health areas and are implemented in communities that are disproportionately affected. Nationwide, nonprofit hospitals and local public health departments conduct community health assessments to guide community prevention investments. California state and federal laws require that nonprofit hospitals conduct a community health needs assessment (CHNA) every three years. Nationally, state, local, and tribal health departments pursue public health accreditation from the national Public Health Accreditation Board (PHAB), and a community health assessment (CHA) is a required component. Though titled differently, CHNAs and CHAs both focus on important key components: using a systematic collection and analysis of data; reporting on the health status, health needs, and other key social determinants of health for the community; ensuring community engagement and input; fostering collective participation; and identifying community assets and resources.

The definition of a community health need is similar for the CHNA and the CHA. Federal regulations define *health needs* as follows: "Health needs include requisites for the improvement or maintenance of health status in both the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities)."[2] Meanwhile, PHAB refers to health needs as "those demands required by a population or community to improve their health status."[3] Both CHNAs and CHAs guide the development of community health improvement efforts aimed at addressing the identified needs. Hospital CHNAs refer to these as implementation plans, while public health agencies call them community health improvement plans or CHIPs. Given the similarities between the CHNA and

[2] *Federal Register*, Vol. 79, No. 250, (Wednesday, December 31, 2014). Department of the Treasury, Internal Revenue Service.
[3] Public Health Accreditation Board (2011, September). Acronyms and Glossary of Terms, Version 1.0.

CHA processes, national experts are calling for nonprofit hospitals and public health departments to work together on local health assessments and community health improvement efforts.[4]

The collaborative work featured in this report will be referred to as CHNA though meeting the requirements for both federal requirements for hospitals and PHAB. This report documents the processes, methods, and findings of a collaborative CHNA conducted on behalf of a partnership between Sutter Davis Hospital (Sutter Health), Woodland Memorial Hospital and Yolo County Health and Human Services Community Health Branch. Additional partners involved in the CHNA included CommuniCare Health Centers and Winters Healthcare. The collaboration between the hospitals and the county emphasizes a team approach to addressing the key components of the CHNA. Each partner was committed to the process, engaged in regular meetings, provided timely feedback to analysis, and willingly shared expertise to support the successful completion of the report. The CHNA was conducted over a period of one year beginning in February 2021 and concluding in February 2022. This CHNA report meets the requirements of the Patient Protection and Affordable Care Act (and in California of Senate Bill 697). In addition, this report meets the requirements set out by PHAB for conducting a CHA as a part of a local health department's needs assessment.

Community Health Insights (www.communityhealthinsights.com) conducted the CHNA on the behalf of the collaborative. Community Health Insights is a Sacramento-based, research-oriented consulting firm dedicated to improving the health and well-being of communities across Central and Northern California. Community Health Insights has conducted dozens of CHNAs and CHAs for multiple health systems and local health departments over the previous decade.

Findings

Prioritized Significant Health Needs

Primary and secondary data were analyzed to identify and prioritize the significant health needs in the Yolo service area. In all, 11 significant health needs were identified. Primary data were then used to prioritize these significant health needs. Findings are presented first to highlight the outcome upfront in the report, followed by a methods overview. Detailed methods are found in the technical section.

Prioritization was based on four measures of community input. The first two measures came from the key informant interview and focus group results. These included the percentage of sources that identified a health need as existing in the community, and the percentage of times the sources identified a health need as a top priority. The last two measures were based on survey data. These include the percentage of service provider survey respondents that identified a health need as a top priority, and the percentage of top priority themes from the community survey that were associated with a health need. Table 1 shows the values of these measures for each significant health need.

[4] Burnett, K. (2012, February). Best Practices for Community Health Needs Assessment and Implementation Strategy Development: A review of scientific methods, current practices, and future potential. Public Health Institute on behalf of Center for Disease Control and Prevention.

Table 1 : Health need prioritization inputs for Yolo service area.

Prioritized Health Needs	Percentage of Key Informants and Focus Groups Identifying Health Need	Percentage of Times Key Informants and Focus Groups Identified Health Need as a Top Priority	Percentage of Provider Survey Respondents that Identified Health Need as a Top Priority	Percentage of Top Priority Themes from Community Survey Associated with the Health Need
Access to Basic Needs Such as Housing, Jobs, and Food	94%	39%	50%	37%
Access to Mental/Behavioral Health and Substance Use Services	88%	22%	50%	37%
Injury and Disease Prevention and Management	75%	3%	21%	37%
Active Living and Healthy Eating	62%	9%	21%	21%
Access to Quality Primary Care Health Services	88%	7%	21%	5%
System Navigation	81%	4%	29%	~
Access to Specialty and Extended Care	38%	3%	36%	5%
Increased Community Connections	69%	3%	21%	~
Safe and Violence-Free Environment	56%	3%	~	5%
Access to Functional Needs	56%	6%	~	~
Access to Dental Care and Preventive Services	19%	~	14%	~

~ Health need not mentioned

These measures were then combined to create a health need prioritization index. The highest priority was given to health needs that were more frequently mentioned and that were more frequently identified among the top priority needs.[5] The prioritization index values are shown in Figure 1, where health needs are ordered from highest priority at the top to lowest priority at the bottom.

[5] Further details regarding the creation of the prioritization index can be found in the technical section.

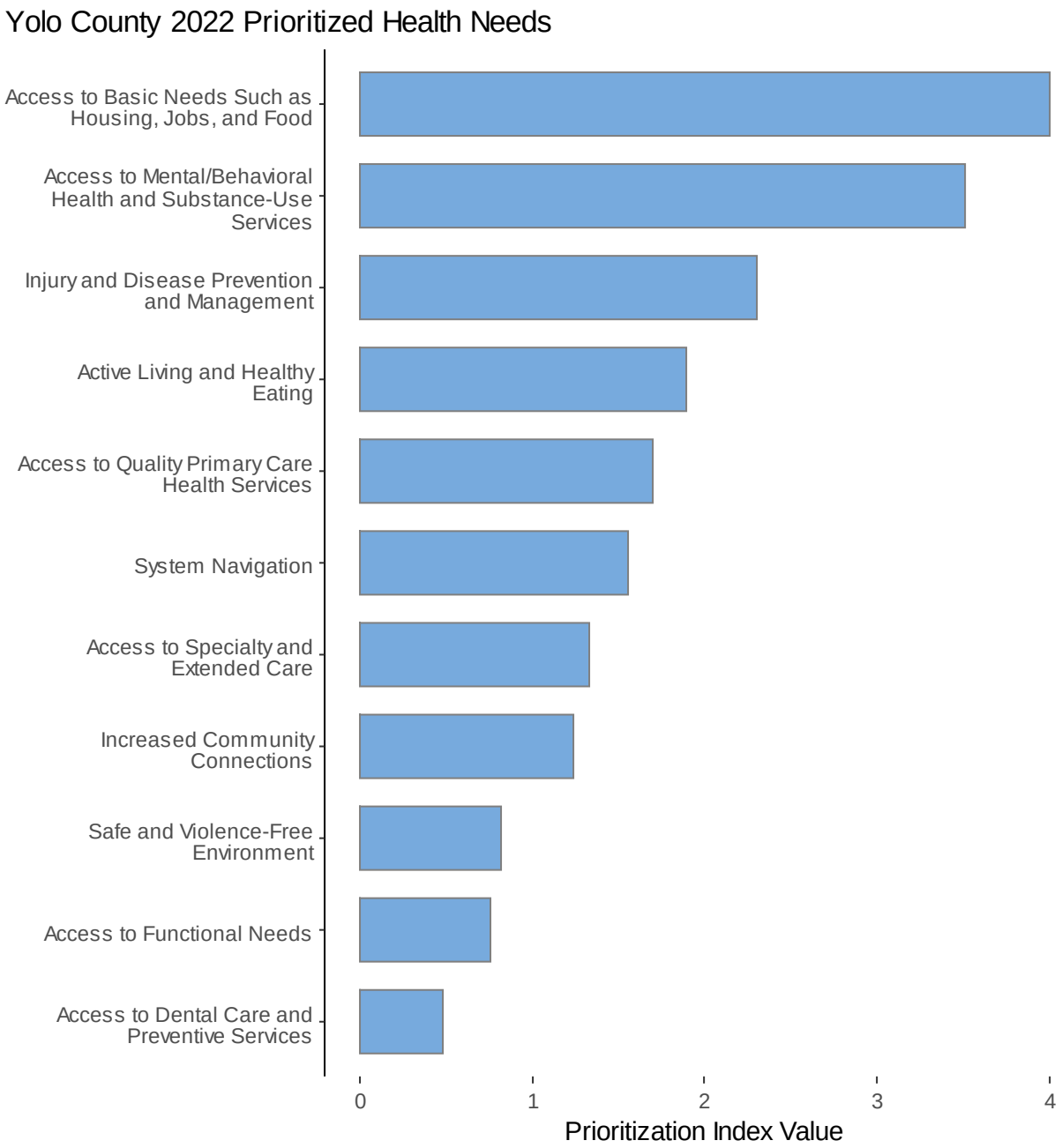

Figure 1: Prioritized, significant health needs for Yolo service area

COVID-19 was top of mind for many participating in the primary data collection process, and feedback regarding the impact of COVID-19 confirmed that the pandemic exacerbated existing needs in the community.

The significant health needs are described below. Those secondary data indicators used in the CHNA that performed poorly compared to benchmarks are listed in the table below each significant health and ordered by their relationship to the conceptual model. Results from primary data analysis are also provided in the table. (A full listing of all quantitative indicators can be found in the technical section). Community Survey responses by question number ("Q") are also provided. For a full description of the question see the technical section.

1. Access to Basic Needs Such as Housing, Jobs, and Food

Access to affordable and clean housing, stable employment, quality education, and adequate food for good health are vital for survival. Maslow's Hierarchy of Needs[6] suggests that only when people have their basic physiological and safety needs met can they become engaged members of society and self-actualize or live to their fullest potential, including enjoying good health. Research shows that the social determinants of health, such as quality housing, adequate employment and income, food security, education, and social support systems, influence individual health as much as health behaviors and access to clinical care.

<table>
<tr><th colspan="3">Primary Data Analysis</th><th>Secondary Data Analysis</th></tr>
<tr><td colspan="3">The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and respondents of the Service Provider and Community surveys.</td><td rowspan="2">The following indicators performed worse in the county when compared to state averages:</td></tr>
<tr><td>Key Informant and Focus Group Responses</td><td>Service Provider Survey Responses</td><td>Community Survey Responses</td></tr>
<tr>
<td>- Many residents struggle with food insecurity.
- The area needs additional low-income housing options.
- Lack of affordable housing is a significant issue in the area.
- Poverty in the county is high.
- Services for homeless residents in the area are insufficient.
- Services are inaccessible for Spanish-speaking and immigrant residents.
- It is difficult to find affordable childcare.
- Many people in the area do not make a living wage.
- Employment opportunities in the area are limited.
- There is a need in the county for dependent living facilities.</td>
<td>- It is difficult to find affordable childcare.
- Lack of affordable housing is a significant issue in the area.
- Many people in the area do not make a living wage.
- The area needs additional low-income housing options.
- Many residents struggle with food insecurity.
- Poverty in the county is high.
- Educational attainment in the area is low.
- Services for homeless residents in the area are insufficient.</td>
<td>- Q10a: Told Lung Disease
- Q21b: No Screening
- Under Insured
- Q21e: No Screening Lacking Trust
- Q50: No Home Internet</td>
<td>- Hypertension Mortality
- Emergency Department (ED) Visits for Dental Diagnosis Adult
- ED Falls Ages 65+
- Hospitalizations for Falls Ages 65+
- Poor Mental Health Days
- Frequent Mental Distress
- Poor Physical Health Days
- Frequent Physical Distress
- Adult Obesity
- Food Environment Index
- Medically Underserved Area
- English Language Learners
- Third Grade Math Level
- Unemployment
- Median Household Income
- Income Inequality</td>
</tr>
</table>

[6] McLeod, S. 2014. Maslow's Hierarchy of Needs. Retrieved from: http://www.simplypsychology.org/maslow.html

- Insurance coverage for mental health care in the county is very hard to obtain. - Digital divide is a big issue in the county, especially for rural residents. - Lack of technology/computer literacy directly limits access to many basic needs during the COVID-19 pandemic. - There is increased need for senior housing and spaces to recreate, socialize. - A functional local food system for the entire county is needed.	- Employment opportunities in the area are limited. - Services are inaccessible for Spanish-speaking and immigrant residents.		- Homeownership - Households with no Vehicle Available

2. Access to Mental/Behavioral Health and Substance-Use Services

Individual health and well-being are inseparable from individual mental and emotional outlook. Coping with daily life stressors is challenging for many people, especially when other social, familial, and economic challenges occur. Access to mental, behavioral, and substance use services is an essential ingredient for a healthy community where residents can obtain additional support when needed.

Primary Data Analysis			**Secondary Data Analysis**
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and respondents of the Service Provider and Community surveys.			The following indicators performed worse in the county when compared to state averages:
Key Informant and Focus Group Responses	Service Provider Survey Responses	Community Survey Responses	
- There aren't enough mental health providers or treatment centers in the area, e.g., psychiatric beds, therapists, support groups. - Additional services specifically for youth are needed (e.g., child psychologists, counselors, and therapists in schools).	- There aren't enough mental health providers or treatment centers in the area (e.g., psychiatric beds, therapists, support groups). - Substance use is a problem in the area (e.g., use of opiates and	- Q10h: Told Mental Illness - Q11: Needed Mental Health Care	- Liver Cancer Mortality - Liver Disease Mortality - Hospitalizations for Mental Health Young Adults - Hospitalizations for Mental Health or Substance Use - Poor Mental Health Days

- The area lacks the infrastructure to support acute mental health crises. - It's difficult for people to navigate mental/ behavioral healthcare. - The stigma around mental health treatment keeps people from seeking care. - The cost for mental/ behavioral health treatment is too high. - There are too few substance use treatment services in the area (e.g., detox centers, rehabilitation centers). - Substance use is an issue among area youth. - There aren't enough services here for those who are homeless and dealing with substance use issues. - Adverse Childhood Experiences (ACEs) are a contributor to alcohol and substance use in the county. - Mental health services are needed for dementia and Alzheimer patients and families. - There is increased need for workforce development to encourage young people to enter the mental health field in the future. - Supportive housing for communities experiencing mental	methamphetamine, prescription misuse). - There aren't enough services here for those who are homeless and dealing with substance use issues. - Additional services for those who are homeless and experiencing mental/behavioral health issues are needed. - It's difficult for people to navigate mental/behavioral healthcare. - There are too few substance use treatment services in the area (e.g., detox centers, rehabilitation centers). - Additional services specifically for youth are needed (e.g., child psychologists, counselors, and therapists in schools). - Awareness of mental health issues among community members is low. - The area lacks the infrastructure to support acute		- Frequent Mental Distress - Poor Physical Health Days - Frequent Physical Distress - Excessive Drinking - Adult Smoking - Mental Health Care Shortage Area - Medically Underserved Area - Mental Health Providers - Juvenile Arrest Rate - Income Inequality

illness is highly needed in the county. - Transportation to get to needed mental health care services is lacking. - Violence and injury in Yolo County have increased due to declining mental health.	mental health crises. - The stigma around mental health treatment keeps people from seeking care. - Treatment options in the area for those with Medi-Cal are limited. - Substance use is an issue among youth in particular. - Substance use treatment options for those with Medi-Cal are limited. - Mental/behavioral health services are available in the area, but people do not know about them. - The cost for mental/behavioral health treatment is too high. - The use of nicotine delivery products such as e-cigarettes and tobacco are a problem in the community.		

3. Injury and Disease Prevention and Management

Knowledge is important for individual health and well-being, and efforts aimed at injury and disease prevention are powerful vehicles to improve community health. When community residents lack adequate information on how to prevent, manage, and control their health conditions, those conditions tend to worsen. Prevention efforts focus on reducing cases of injury and infectious disease control (e.g., sexually transmitted infection (STI) prevention and influenza shots), and intensive strategies in the management of chronic diseases (e.g., diabetes, hypertension, obesity, and heart disease) are important for community health improvement.

Primary Data Analysis			Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and respondents of the Service Provider and Community surveys.			The following indicators performed worse in the county when compared to state averages:
Key Informant and Focus Group Responses	Service Provider Survey Responses	Community Survey Responses	
- There should be a greater focus on chronic disease prevention (e.g., diabetes, heart disease). - Prevention efforts need to be focused on specific populations in the community (e.g., youth, Spanish-speaking residents, the elderly, LGBTQ individuals, immigrants). - There is increased homelessness in the region, especially West Sacramento and Woodland. - There isn't really a focus on prevention in Yolo County. - The community needs nutrition education opportunities. - Patients need to be better connected to service providers (e.g., case management, patient navigation, or centralized service provision). - Many residents in the county lack the	- Health education in schools needs to be improved. - Patients need to be better connected to service providers (e.g., case management, patient navigation, or centralized service provision). - The community needs nutrition education opportunities. - There isn't really a focus on prevention around here. - There should be a greater focus on chronic disease prevention (e.g., diabetes, heart disease).	- Q10a: Told Lung Disease - Q10b: Told Autoimmune Disease - Q10d: Told Diabetes - Q10h: Told Mental Illness	- Chronic Lower Respiratory Disease Mortality - Hypertension Mortality - Liver Cancer Mortality - Liver Disease Mortality - Alzheimer's Disease Mortality - Emergency Department (ED) Visits for Dental Diagnosis Adult - ED Falls Ages 65+ - Hospitalizations for Falls Ages 65+ - Hospitalizations for Mental Health Young Adults - Hospitalizations for Mental Health or Substance Use - Poor Mental Health Days - Frequent Mental Distress - Frequent Physical Distress - Excessive Drinking

financial means and basic technology to access health information. - Vaping prevention in the county is needed.			- Adult Obesity - Adult Smoking - Juvenile Arrest Rate - Motor Vehicle Crash Death - Third Grade Math Level - Income Inequality

4. Active Living and Healthy Eating

Physical activity and eating a healthy diet are important for one's overall health and well-being. Frequent physical activity is vital for prevention of disease and maintenance of a strong and healthy heart and mind. When access to healthy foods is challenging for community residents, many turn to unhealthy foods that are convenient, affordable, and readily available. Communities experiencing social vulnerability and poor health outcomes often live in areas with fast food and other establishments where unhealthy food is sold. Under-resourced communities may be challenged with food insecurity, absent the means to consistently secure food for themselves or their families, relying on food pantries and school meals often lacking in sufficient nutrition for maintaining health.

Primary Data Analysis			**Secondary Data Analysis**
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and respondents of the Service Provider and Community surveys.			The following indicators performed worse in the county when compared to state averages:
Key Informant and Focus Group Responses	Service Provider Survey Responses	Community Survey Responses	
- Food insecurity is a concern in the county, especially for college students and those living in rural areas. - The community needs nutrition education programs. - Grocery store options in the area are limited especially in rural areas of the county. - Fresh, unprocessed foods are unaffordable.	- Homelessness in parks or other public spaces deters residents from their use. - Recreational opportunities in the area are unaffordable (e.g., gym memberships, recreational activity programming). - There aren't enough recreational opportunities in the area (e.g., organized	- Q10d: Told Diabetes	- Hypertension Mortality - Liver Cancer Mortality - Poor Mental Health Days - Frequent Mental Distress - Poor Physical Health Days - Frequent Physical Distress - Breast Cancer Prevalence - Adult Obesity - Food Environment Index - Income Inequality

- The built environment doesn't support physical activity (e.g., neighborhoods aren't walkable, roads aren't bike-friendly, or parks are inaccessible). - Improvements are needed in the food system to reduce targeting of highly processed foods to poor and disenfranchised community residents. - Kids need healthier food options to avoid early onset chronic disease development. - Food distribution to residents that are isolated geographically or medically is lacking.	activities, youth sports leagues). - Food insecurity is an issue here. - Fresh, unprocessed foods are unaffordable. - Grocery store options in the area are limited. - The built environment doesn't support physical activity (e.g., neighborhoods aren't walkable, roads aren't bike-friendly, or parks are inaccessible). - The community needs nutrition education programs. - The food available in local homeless shelters and food banks is not nutritious.		

5. Access to Quality Primary Care Health Services

Primary care resources include community clinics, pediatricians, family practice physicians, internists, nurse practitioners, pharmacists, telephone advice nurses, and other similar resources. Primary care services are typically the first point of contact when an individual seeks healthcare. These services are the front line in the prevention and treatment of common diseases and injuries in a community.

Primary Data Analysis			**Secondary Data Analysis**
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and respondents of the Service Provider and Community surveys.			The following indicators performed worse in the county when compared to state averages:
Key Informant and Focus Group Responses	Service Provider Survey Responses	Community Survey Responses	
- The quality of care is low (e.g.,	- It is difficult to recruit and retain	- Q10d: Told Diabetes	- Chronic Lower Respiratory

appointments are rushed, providers lack cultural competence). - There aren't enough primary care service providers in the area. - Transportation is a significant barrier to accessing primary care for many residents due to physical distance. - Increased access to healthcare via telehealth, mobile health, street health is needed in the county. - Specific services are unavailable here (e.g., 24-hour pharmacies, urgent care, telemedicine). - Quality health insurance is unaffordable. - Patients seeking primary care overwhelm local emergency departments. - Primary care services are available but are difficult for many people to navigate. - There is a need for increased access to preventative care including screenings. - There is desire for health care systems, law enforcement and other providers to work together to	primary care providers in the region. - Out-of-pocket costs are too high. - Patients have difficulty obtaining appointments outside of regular business hours. - Patients seeking primary care overwhelm local emergency departments. - Primary care services are available but are difficult for many people to navigate. - Specific services are unavailable here (e.g., 24-hour pharmacies, urgent care, telemedicine). - There aren't enough primary care service providers in the area. - Too few providers in the area accept Medi-Cal.	- Q21d: No Screening Transportation - Q21k: No Screening Clinic Hours - Q21l: No Screening Doctor Availability - Q21b: No Screening Under Insured - Q21e: No Screening Lacking Trust - Q23a: ER No Appointment	Disease Mortality - Hypertension Mortality - Liver Cancer Mortality - Liver Disease Mortality - Alzheimer's Disease Mortality - Poor Mental Health Days - Frequent Mental Distress - Poor Physical Health Days - Frequent Physical Distress - Breast Cancer Prevalence - Lung Cancer Prevalence - Medically Underserved Area - Income Inequality

coordinate care for medically vulnerable residents. - Medicare in-home support care is needed in the area. - There is a need for primary care providers to better care for Alzheimer and dementia patients. - Increased funding is needed for local Federally Qualified Health Centers (FQHCs) and Community Clinics to care for undocumented residents.			

6. System Navigation

System navigation refers to an individual's ability to traverse fragmented social services and healthcare systems in order to receive the necessary benefits and supports to improve health outcomes. Research has demonstrated that navigating the complex U.S. healthcare system is a barrier for many that results in health disparities.[7] Furthermore, accessing social services provided by government agencies can be an obstacle for those with limited resources such as transportation access and English proficiency.

Primary Data Analysis			**Secondary Data Analysis**
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and respondents of the Service Provider and Community surveys.			The following indicators performed worse in the county when compared to state averages:
Key Informant and Focus Group Responses	Service Provider Survey Responses	Community Survey Responses	
- It is difficult for people to navigate multiple, different healthcare and social support systems. - Some people just don't know where to start in order to	- It is difficult for people to navigate multiple, different healthcare systems. - Some people just don't know where to start in order to	No data.	- Liver Cancer Mortality

[7] Natale-Pereira, A. et. al .2011. The Role of Patient Navigators in Eliminating Health Disparities. US National Library of Medicine, National Institutes of Health, 117:15, 3543-3552.

access care or benefits. - People have trouble understanding their insurance benefits. - System navigation for foster care in the county needs improvement. - Coordinating and centralizing services/care would reduce system navigation barriers.	access care or benefits. - Automated phone systems can be difficult for those who are unfamiliar with the healthcare system. - Dealing with medical and insurance paperwork can be overwhelming. - People have trouble understanding their insurance benefits. - People may not be aware of the services they are eligible for. - Medical terminology is confusing. - The area needs more navigators to help to get people connected to services.		

7. Access to Specialty and Extended Care

Extended care services, which include specialty care, are care provided in a particular branch of medicine and focused on the treatment of a particular disease. Primary and specialty care go hand in hand, and without access to specialists, such as endocrinologists, cardiologists, and gastroenterologists, community residents are often left to manage the progression of chronic diseases, including diabetes and high blood pressure, on their own. In addition to specialty care, extended care refers to care extending beyond primary care services that is needed in the community to support overall physical health and wellness, such as skilled-nursing facilities, hospice care, and in-home healthcare.

Primary Data Analysis			**Secondary Data Analysis**
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and respondents of the Service Provider and Community surveys.			The following indicators performed worse in the county when compared to state averages:
Key Informant and Focus Group Responses	Service Provider Survey Responses	Community Survey Responses	

- The area needs more extended care options for the aging population (e.g., skilled nursing homes, in-home care). - Not all specialty care is covered by insurance. - There is a need for specialty care that meets residents where they are as well as reduced barriers to navigation and transportation. - There is increased need for respite care in the county.	- Not all specialty care is covered by insurance. - People have to travel to reach specialists. - The area needs more extended care options for the aging population (e.g., skilled nursing homes, in-home care). - Additional hospice and palliative care options are needed. - It is difficult to recruit and retain specialists in the area. - Out-of-pocket costs for specialty and extended care are too high. - Wait times for specialist appointments are excessively long. - Too few specialty and extended care providers accept Medi-Cal.	- Q10d: Told Diabetes	- Chronic Lower Respiratory Disease Mortality - Hypertension Mortality - Liver Cancer Mortality - Liver Disease Mortality - Alzheimer's Disease Mortality - Poor Mental Health Days - Frequent Mental Distress - Poor Physical Health Days - Frequent Physical Distress - Lung Cancer Prevalence - Income Inequality

8. Increased Community Connections

As humans are social beings, community connection is a crucial part of living a healthy life. People have a need to feel connected with a larger support network and the comfort of knowing they are accepted and loved. Research suggests "individuals who feel a sense of security, belonging, and trust in their community have better health. People who don't feel connected are less inclined to act in healthy ways or work with others to promote well-being for all."[8] Assuring that community members have ways to connect with each other through programs, services, and opportunities is important in fostering a healthy community. Furthermore, healthcare and community support services are more effective when they are delivered in a coordinated fashion, where individual organizations collaborate with others to build a network of care.

[8] Robert Wood Johnson Foundation. 2016. Building a Culture of Health: Sense of Community. Retrieved from: https://www.rwjf.org/en/cultureofhealth/taking-action/making-health-a-shared-value/sense-of-community.html

Primary Data Analysis			Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and respondents of the Service Provider and Community surveys.			The following indicators performed worse in the county when compared to state averages:
Key Informant and Focus Group Responses	Service Provider Survey Responses	Community Survey Responses	
- Health and social service providers operate in silos; more cross-sector connection/collaboration is needed. - Relations between law enforcement, health care systems, and the community need to be better coordinated. - The community needs to invest more in local public schools and activities for young people. - People in the community lack representation of BIPOC (Black and Indigenous People of Color) communities in local service providers. - City and county leaders need to work together. - Public Health is severely under-funded in the county. - More intentional efforts are needed to reduce isolation and bring the community together (e.g., community center, community events, activities). - Increased inclusion of the community voice is needed in countywide decision-making.	- City and county leaders need to work together. - Cross-sector connections are needed. - Health and social service providers operate in silos. - Relations between law enforcement and the community need to be improved. - Building community connections doesn't seem like a focus in the area. - People in the community face discrimination from local service providers. - The community needs to invest more in local public schools. - There isn't enough funding for social services in the county.	No data.	- Hypertension Mortality - Hospitalizations for Mental Health Young Adults - Hospitalizations for Mental Health or Substance Use - Poor Mental Health Days - Frequent Mental Distress - Poor Physical Health Days - Frequent Physical Distress - Excessive Drinking - Mental Health Care Shortage Area - Medically Underserved Area - Mental Health Providers - Juvenile Arrest Rate - Unemployment - Income Inequality - Households with no Vehicle Available

9. Safe and Violence-Free Environment

Feeling safe in one's home and community is fundamental to overall health. Next to having basic needs met (e.g., food, shelter, and clothing) is having physical safety. Feeling unsafe affects the way people act and react to everyday life occurrences. Furthermore, research has demonstrated that individuals exposed to violence in their homes, the community, and schools are more likely to experience depression and anxiety and demonstrate more aggressive, violent behavior.[9]

<table>
<tr><th colspan="3">Primary Data Analysis</th><th>Secondary Data Analysis</th></tr>
<tr><td colspan="3">The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and respondents of the Service Provider and Community surveys.</td><td rowspan="2">The following indicators performed worse in the county when compared to state averages:</td></tr>
<tr><td>Key Informant and Focus Group Responses</td><td>Service Provider Survey Responses</td><td>Community Survey Responses</td></tr>
<tr><td>- There are not enough resources to address domestic violence and sexual assault in the county.
- Safe public parks and green space are lacking, areas often have criminal activity.
- County has seen noticeable increase in criminal activity and acts of gun violence.
- Health care professionals are not trained to properly treat residents experiencing the increase threats to safety.
- Lack of housing increases criminal activity in the county.</td><td>No data.</td><td>No data.</td><td>- Hypertension Mortality
- Hospitalizations for Mental Health Young Adults
- Hospitalizations for Mental Health or Substance Use
- Poor Mental Health Days
- Frequent Mental Distress
- Frequent Physical Distress
- Juvenile Arrest Rate
- Motor Vehicle Crash Death
- Income Inequality</td></tr>
</table>

10. Access to Functional Needs

Functional needs includes adequate transportation access and conditions which promote access for individuals with physical disabilities. Having access to transportation services to support individual mobility is a necessity of daily life. Without transportation, individuals struggle to meet their basic needs, including those needs that promote and support a healthy life. The number of people with a disability is

[9] Lynn-Whaley, J., & Sugarmann, J. July 2017. The Relationship Between Community Violence and Trauma. Los Angeles: Violence Policy Center.

also an important indicator for community health and must be examined to ensure that all community members have access to necessities for a high quality of life.

<table>
<tr><th colspan="3">Primary Data Analysis</th><th>Secondary Data Analysis</th></tr>
<tr><td colspan="3">The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and respondents of the Service Provider and Community surveys.</td><td rowspan="2">The following indicators performed worse in the county when compared to state averages:</td></tr>
<tr><td>Key Informant and Focus Group Responses</td><td>Service Provider Survey Responses</td><td>Community Survey Responses</td></tr>
<tr><td>- Many residents do not have reliable personal transportation.
- Public transportation service routes are limited.
- Public transportation is more difficult for some residents to use (e.g., non-English-speaking).
- The distance between service providers is inconvenient for those using public transportation.
- Using public transportation to reach providers can take a very long time.
- The cost of public transportation is too high.
- Public transportation schedules are limited.
- The geography of the area makes it difficult for those without reliable transportation to get around.
- Increased usage of telehealth/mobile medicine would reduce transportation barriers.</td><td>No data.</td><td>- Q21d: No Screening Transportation</td><td>- Emergency Department (ED) Falls Ages 65+
- Hospitalizations for Falls Ages 65+
- Frequent Mental Distress
- Frequent Physical Distress
- Adult Obesity
- Income Inequality
- Households with no Vehicle Available</td></tr>
</table>

11. Access to Dental Care and Preventive Services

Oral health is important for overall quality of life. When individuals have dental pain, it is difficult to eat, concentrate, and fully engage in life. Oral health disease, including gum disease and tooth decay are

preventable chronic diseases that contribute to increased risk of other chronic disease, as well as play a large role in chronic absenteeism from school in children. Poor oral health status impacts the health of the entire body, especially the heart and the digestive and endocrine systems.

<table>
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<tr><td colspan="3">The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and respondents of the Service Provider and Community surveys.</td><td rowspan="2">The following indicators performed worse in the county when compared to state averages:</td></tr>
<tr><td>Key Informant and Focus Group Responses</td><td>Service Provider Survey Responses</td><td>Community Survey Responses</td></tr>
<tr><td>- Mobile dental services are needed in isolated areas of the county.
- Dental caries in the county are high, especially in children.
- Assuring adequate access to dental care in Yolo County is important.</td><td>- It's hard to get an appointment for dental care.
- Quality dental services for kids are lacking.
- There aren't enough providers in the area who accept Denti-Cal.
- Dental care here is unaffordable, even if you have insurance.
- People in the area have to travel to receive dental care.
- The lack of access to dental care here leads to overuse of emergency departments.
- There aren't enough dental providers in the area.</td><td>- Q49: Had Dental Visit</td><td>- Emergency Department (ED) Visits for Dental Diagnosis Adult
- Frequent Mental Distress
- Poor Physical Health Days
- Frequent Physical Distress
- Dentists
- Income Inequality</td></tr>
</table>

Other Health Needs

Systems Change
Key informant and focus group participants spoke about a need for systems, policies, and environments to change in order to better support the health needs of Yolo County residents. Many community health problems cannot be improved solely by individual actions, but by community systems coming together to forge an environment where healthy choices are easy and popular. Though the volume of data did not warrant being listed as a significant priority health need, the mention was so pervasive in the data that it is detailed below.

- Sustainable funding is a must in order to cause lasting change in community prevention efforts. It is very challenging when new programs and organizations have unstable fundings sources and change frequently.
- Resources to fund increased capacity of existing health care and social services agencies is needed in order to better meet the needs of the community.
- Better coordination between law enforcement and health/social services is needed to properly care for those struggling with mental illness and homelessness in the county.
- Increased for social service staff to be culturally reflective of the community they serve.
- Public health is severely underfunded.
- System of care needs to change to better protect the victims of abuse.
- Health in all policy is needed in all sectors.
- Investment in the digital divide for rural areas of the county is an urgent need.
- Housing system (lack of affordable housing, location, and type of affordable housing, etc.) in the county is a major threat to the health and safety of community members.

Healthy Physical Environment
The data assigned to PHN 9 Healthy Physical Environment did not meet the criteria of a significant health need for Yolo County as defined by the analytical process used for this assessment. A healthy and clean physical environment is very important for the overall health of the community. As a healthy physical environment affects and is affected by all other health factors and conditions, partners for this assessment will continue to look for ways to collaborate on projects aimed at improving and maintaining a healthy physical environment.

Method Overview

Conceptual and Process Models

The data used to conduct the assessment were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model.[10] This model of population health includes the many factors that impact and account for individual health and well-being. Furthermore, to guide the overall process of conducting the assessment, a defined set of data collection and analytical stages were developed. For a detailed review of methods, see the technical section.

Public Comments from Previously Conducted CHNAs

Regulations require that nonprofit hospitals include written comments from the public on their previously conducted CHNAs and most recently adopted Implementation Strategy. Both Woodland Memorial Hospital and Sutter Davis Hospital requested written comments from the public on their 2019 CHNA and most recently adopted Implementation Strategy.

[10] County Health Rankings Model, Robert Wood Johnson Foundation, and University of Wisconsin, 2021. Retrieved from: http://www.countyhealthrankings.org/.

At the time of the development of this CHNA report, neither partner had received any comments. However, input from the broader community was incorporated in the 2022 CHNA through key informant interviews, focus groups, a Community Health Status Survey, and the Service Provider Survey. The Yolo County collaborative partners will continue to use their respective websites as tools to solicit public comments and ensure that these comments are integrated as community input in the development of future health assessments.

Data Used in the CHNA

Data collected and analyzed included both primary and secondary data. Primary data included 13 interviews with 29 community health experts, 3 focus groups conducted with a total of 18 community residents or community-facing service providers, a Community Health Status Survey of 1,574 community residents and 14 responses to the Service Provider Survey. (A full listing of all participants can be seen in the technical section.)

Secondary data included multiple datasets selected for use in the various stages of the analysis. A combination of mortality and socioeconomic datasets collected at subcounty levels was used to identify portions of Yolo County with greater concentrations of populations experiencing undue health burden. A set of county-level indicators was collected from various sources to help identify and prioritize significant health needs. Additionally, socioeconomic indicators were collected to help describe the overall social conditions within the county. Health outcome indicators included measures of both mortality (length of life) and morbidity (quality of life). Health factor indicators included measures of 1) health behaviors, such as diet and exercise and tobacco, alcohol, and drug use; 2) clinical care, including access to quality care; 3) social and economic factors such as race/ethnicity, income, educational attainment, employment, neighborhood safety, and similar; and 4) physical environment measures, such as air and water quality, transit and mobility resources, and housing affordability. In all, 100 different health outcome and health factor indicators were collected for the health assessment.

Data Analysis

Primary and secondary data were analyzed to identify and prioritize the significant health needs for Yolo County. This included identifying 12 potential health needs (PHNs) in these communities. These potential health needs were those identified in previously conducted CHNAs. Data were analyzed to discover which, if any, of the PHNs were present in the county. After these were identified, health needs were prioritized based on an analysis of primary data sources that described the PHN as a significant health need.

For an in-depth description of the processes and methods used to conduct the CHNA, including primary and secondary data collection, analysis, and results, see the technical section.

Description of Community Served

Yolo County was one of 27 original counties when California became a state in 1850 and is home to well over 200,000 residents. It is located directly west of Sacramento and sits along both the Interstate 5 and 80 corridors. The county is considered a part of the Greater Sacramento metropolitan area and is located in the Sacramento Valley. Yolo County covers over 1,000 square miles, and a large portion is dedicated to agriculture.

Yolo County is governed by a board of supervisors and contains four incorporated cities: Davis, West Sacramento, Winters, and Woodland. While Davis is the largest city in terms of population, Woodland serves as the County Seat. West Sacramento is home to the Port of West Sacramento, an inland port some

80 nautical miles from San Francisco. The port exports many of the agricultural products grown in the County. The Yolo Causeway connects Davis and Sacramento along Interstate 80, and crosses the Yolo Bypass, a large floodplain and wildlife area that received national attention in the late 1990's as a national model for public/private restoration projects.

The City of Woodland has a strong historic heritage and serves as the primary support community for agricultural services. Davis is a unique university community that is internationally known for its commitment to environmental awareness and progressive and socially innovative programs. Winters is a small city located on Putah Creek in the western part of Yolo County and is home to a thriving agricultural industry. West Sacramento sits on the Sacramento River, on the east side of Yolo County, and is home to the Port of Sacramento, which ships over a million tons of agricultural products to worldwide markets. The county is known for growing and processing tomatoes. Less than a quarter of the region's population resides in unincorporated communities, including Esparto, the gateway to Capay Valley, Madison, Yolo, Dunnigan, Clarksburg, Guinda, Knights Landing, Monument Hills, Capay, Plainfield, Brooks, Rumsey, El Macero, and Zamora. Arbuckle and portions of Dixon are designated as Health Professional Shortage Areas by the U.S. Health Resources and Services Administration.

The total population of the county was 217,352 in 2020. Race and ethnicity data for Yolo County[11] are presented in Figure 2 and a map of Yolo County is shown in Figure 3.

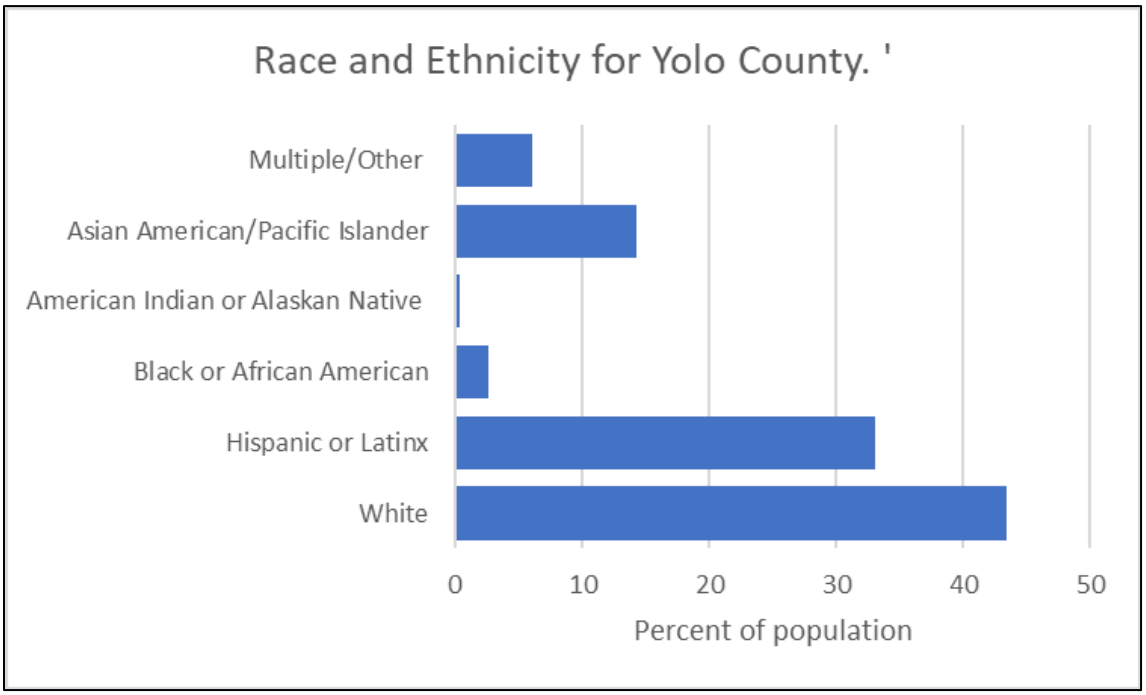


Figure 2: Race and ethnicity for Yolo County.

[11] Race and Ethnicity data for Yolo County are based on 2020 Census data as reported here: https://data.census.gov/cedsci/table?q=Yolo%20County,%20California&tid=DECENNIALPL2020.P2.

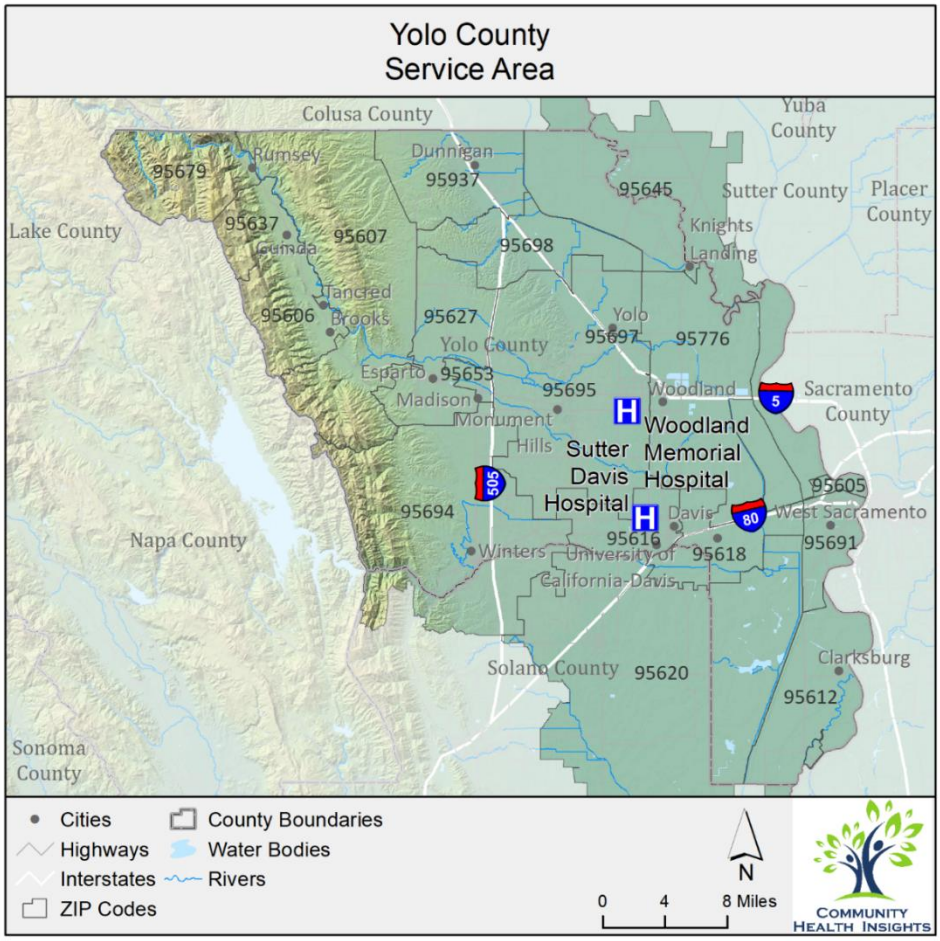


Figure 3: Yolo County Service Area

Population characteristics for each ZIP Code in Yolo County are presented in Table 2. These are compared to the state and county characteristics for descriptive purposes. Any ZIP Code with values that compared negatively to the state or county is highlighted.

Table 2: Population characteristics for each ZIP Code located in Yolo County.

ZIP Code	Total Population	% Non-White or Hispanic\Latinx	Median Age	Median Income	% Poverty	% Unemployment	% Uninsured	% Without High School Graduation	% With High Housing Costs	% With Disability
95605	14,493	58.4	32.3	$51,303	20.6	10.2	5.6	26.3	38.9	12.1
95606	249	70.3	60.1	~	14.1	9	0	19	27.6	55
95607	389	15.4	61.1	$75,964	0	0	0	3.1	21.6	32.4
95612	1,321	46.6	36.1	$95,000	1.2	5.8	3.6	10.8	15.2	3.5
95616	52,212	48	22.9	$55,510	35.6	6.8	3.4	2.1	44.6	6.8

95618	27,519	45.6	31.7	$93,643	22.5	4.7	3	3.5	34.2	7.4
95620	21,954	54	35.1	$82,956	10.2	5.7	7.8	20.7	30.1	11
95627	3,802	59.6	31.9	$75,938	9	4.3	7.8	18.6	26.4	13.6
95637	268	61.6	50.1	$52,917	45.1	0	0	21.4	33	19.4
95645	1,881	76.6	40	$43,696	18.7	10.4	14.4	45	28.1	16
95653	581	99.7	35.3	$41,050	15.7	3.6	11	55.1	57.5	9.8
95679	56	0	48.7	~	0	0	17.9	0	0	26.8
95691	38,690	52.5	34.9	$77,303	13.2	6.3	4	12.8	34.3	9.6
95694	10,495	51	37.3	$84,949	9.5	5.2	5.1	18.7	25.7	9
95695	41,278	53.6	37.7	$64,390	10.5	6.3	7.7	17.8	32.8	12.3
95697	183	69.9	55.3	~	4.9	0	0	44.1	0	23.5
95698	148	16.2	57.5	$26,615	19.6	0	0	30.4	36.4	6.1
95776	23,911	68.6	33.4	$81,184	13.1	4.2	5.4	18.4	36.3	9.9
95937	1,540	53.8	32.1	$51,625	18.3	14.1	6.5	24.3	33.6	16.2
Yolo	217,352	53.3	31	$70,228	19.1	6.2	4.8	13.5	36.1	9.6
California	39,283,497	62.8	36.5	$75,235	13.4	6.1	7.5	16.7	40.6	10.6

Source: 2019 American Community Survey 5-year estimates; U.S. Census Bureau.
~ Data not available.

Health Equity

The following section is a high-level summary of health equity in Yolo County and is not intended to provide an extensive exploration of inequity in the service area. Quantifying and describing inequity in a community is challenging due to data limitations and the fact that inequity is a contributor to all health needs that exist in a community.

The Robert Wood Johnson Foundation's definition of health equity and social justice is used here to help establish a common understanding for the concept of health equity.

"*Health equity means that everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.*"[12]

Inequities experienced early and throughout one's life, such as limited access to a quality education, have health consequences that appear later in life as health disparities. Health disparities are defined as "preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health experienced by populations, and defined by factors such as race or ethnicity, gender, education or income, disability, geographic location or sexual orientation."[13]

[12] Robert Wood Johnsons Foundation. (2017, April). What is Health Equity? And What Difference Does a Definition Make? Health Equity Issue Brief #1.
https://buildhealthyplaces.org/content/uploads/2017/05/health_equity_brief_041217.pdf
[13] Center for Disease Control and Prevention. 2008. Health Disparities Among Racial/Ethnic Populations. Community Health and Program Services (CHAPS): Atlanta: U.S. Department of Health and Human Services.

In the U.S. and many parts of the world, health inequities are most apparent when comparing health outcomes of various racial and ethnic groups to one another. These comparisons clearly demonstrate that health inequities persist across communities, including in Yolo County.

This section of the report follows the organizing framework used throughout this assessment: the Robert Wood Johnson Foundation's County Health Rankings model.[14] The model shows that health outcomes are the result of health factors which one experiences throughout life. Understanding where health disparities exist helps in the planning of targeted interventions to address these and ultimately improve health equity.

Health Outcomes - The Results of Inequity

The table below displays disparities among racial and ethnic groups for Yolo County for life expectancy, mortality, and low birthweight.

Table 3: Health outcomes comparing racial and ethnic groups in Yolo County.

Health Outcomes	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	White
Infant Mortality	Number of all infant deaths (within 1 year), per 1,000 live births.	~	~	~	3.3	4.3
Life Expectancy	Average number of years a person can expect to live.	~	89.7	77.5	84.1	80.6
Child Mortality	Number of deaths among children under age 18 per 100,000 population.	~	~	~	25.2	28.1
Premature Age-Adjusted Mortality	Number of deaths among residents under age 75 per 100,000 population (age-adjusted).	472.6	130.6	507.9	217.5	279.6
Premature Death	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	~	2,098.2	9,065.9	4,298.7	5,038.6
Low Birthweight	Percentage of live births with low birthweight (< 2,500 grams).	~	6.8%	9.1%	5.8%	5.1%

~ Data not available
Data sources are included in the technical section.

Health inequities (by race/ethnicity) specific to health outcomes clearly exist in Yolo County. Black community members in Yolo County have lower life expectancy, higher premature age-adjusted

[14] See: County Health Rankings Model, Robert Wood Johnson Foundation, and University of Wisconsin, 2021. Retrieved from: http://www.countyhealthrankings.org/.

mortality, higher premature death (Years of Potential Life Lost before age 75), and higher percentage of low birthweight babies than other racial/ethnic groups in the area.

Health Factors - Inequities in the County

Data reveal inequities in health factors in the service area, such as education attainment and income. These health factors are displayed in Table 4 and are compared across racial and ethnic groups. The indicators used in this table were selected based their ability to describe inequity across racial and ethnic groups across Yolo County. The inclusion of these particular equity-oriented indicators was also guided by a review of previous research.[15]

Table 4: Health factors by race and ethnicity in Yolo County.

Health Factors	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	White	Overall
Some College[a]	Percentage of adults ages 25 and over with some post-secondary education.	36.7%	81%	71.2%	40.8%	80.2%	68.4%
High School Completion[a]	Percentage of adults ages 25 and over with at least a high school diploma or equivalent.	71.6%	91.3%	93.4%	66.7%	95.6%	86.5%
Third Grade Reading Level	Average grade level performance for 3rd graders on English Language Arts standardized tests.	~	~	2.3	2.5	3.3	2.9
Third Grade Math Level	Average grade level performance for 3rd graders on math standardized tests.	~	3.2	2.1	2.3	3	2.7
Children in Poverty	Percentage of people under age 18 in poverty.	15.8%	16.4%	28.2%	20.6%	8.4%	13%

[15] For example, see: Stillman, L. & Ridini, S. (May 2015). *Embracing Equity in Community Health Improvement*. Health Resources in Action Policy and Practice Report. Accessed: https://hria.org/wp-content/uploads/2016/02/Embracing-Equity-in-Community-Health-Improvement.pdf.

Median Household Income	The income where half of households in a county earn more and half of households earn less.	$48,316	$63,271	$39,813	$54,451	$83,307	$70,951
Uninsured Population[b]	Percentage of the civilian non-institutionalized population without health insurance.	11.9%	4.7%	4.2%	8.2%	2.6%	4.8%

~ Data not available
Unless otherwise noted, data sources are included in the technical section.
[a]From 2019 American Community Survey 5-year estimates tables B15002, C15002B, C15002C, C15002D, C15002H, and C15002I.
[b]From 2019 American Community Survey 5-year estimates table S2701.

Health and social inequities specific to identified health factors reveal clear disparities for American Indian/Alaskan Native, Hispanics, and Black residents of Yolo County. American Indian/Alaskan Native residents have the lowest percentage of community members attending college, the second lowest high school completion rate, and the highest percentage of uninsured residents. Hispanics have a low percentage of community members attending college and completing high school, one of the lowest third grade reading levels, and the largest percentage of uninsured population. Black residents of Yolo County have the lowest third grade reading level, the highest percentage of children in poverty, and the lowest median household income.

Population Groups and Locations Experiencing Disparities

The figure and table that follow describe populations and specific geographic locations in Yolo County identified through qualitative data analysis as experiencing health disparities.

Interview participants were asked two separate questions:

1. What specific groups of community members experience health issues the most?
2. What specific geographic locations struggle with health issues the most?

For populations, responses were analyzed by counting the total number of times all key informants and focus group participants mentioned a particular group as one experiencing disparities. Figure 4 displays the results of this analysis. The groups are not mutually exclusive—one group could be a subset of another group. One of the purposes of identifying the sub-populations was to help guide additional qualitative data collection efforts to focus on the needs of these population groups.

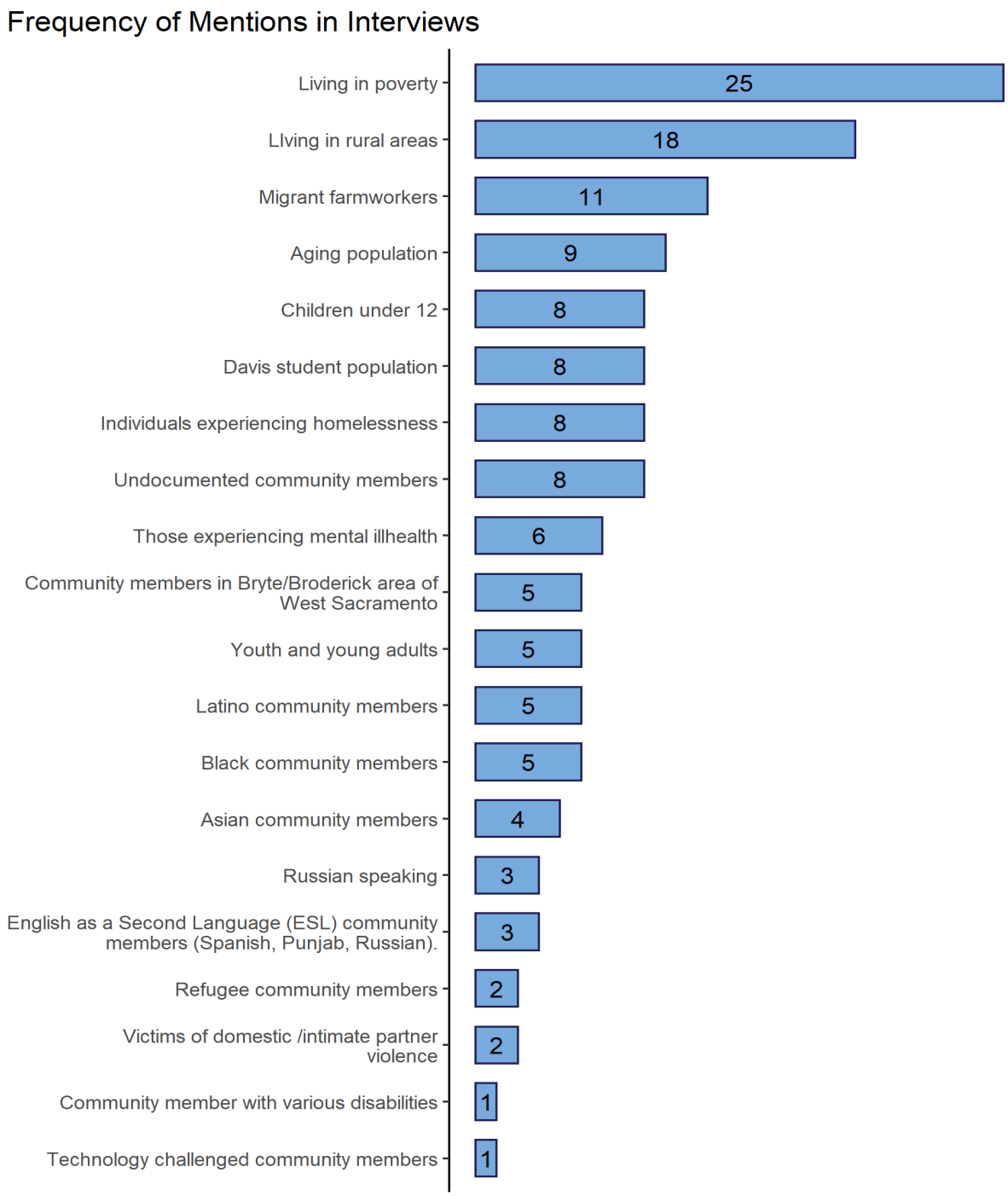


Figure 4: Populations experiencing disparities in Yolo County.

Table 5 details responses from a total of 47 key informants and focus group participants related to geographic locations in Yolo County struggling disproportionately with health issues. The detailed descriptive data from this question are organized by specific location and presented below.

Table 5: Geographic locations struggling with health issues.

"What specific geographic locations struggle with health issues the most?"	
Geographic Locations	**Attributes of Locations**
Clarksburg	Increased drug use and access. Due to decreased police department resources, area has seen rise in crime. Highly dispersed area.
Davis	High student population with food insecurity. Migrant farm worker community. Increased cases of suicide and self-harm. Women's shelters are at capacity. High cases of dementia. Wide distribution of wealth between two main types: high income and low income.
Dunnigan	High rates of poverty. Isolated away from services.
Esparto/Madison	Migrant farm worker community. Small clinic in the area. High dental need. Food insecurity and limited access to health foods. Migrant workers disproportionately affected by COVID due to no paid sick leave – worked through the pandemic. Need for a senior living complex.
Knights Landing	Migrant farm worker community. No community park. Limited access to health foods. UC Davis medical student-run Clinic. Transportation a barrier to access services.
West Sacramento	High poverty, but close to services. High racial/ethnic diversity – Russian, Asian, Hispanic, Afghan, Black. Cultural barriers to care related to services not in their native language. Residents experiencing homelessness. Increased reporting of families living in their vehicles. West Capitol area – 7% African American. High cases of dementia. Need for affordable and safe housing. Few COVID relief programs – all in Davis. **Bryte/Broderick Area:** High rates of poverty, food insecurity, very industrial. Low vaccinations rates and large COVID outbreaks. Abundance of motels, obesity, high rates of mental illness and substance use.
Winters/Capay Valley	Rural Winters - High rates of poverty. Migrant farm worker camp. Transportation a barrier to access services. Must leave area to access health care services. No assisted living opportunities in rural parts. Area outside of Winters city limits, which includes between Winters and Davis, high poverty, isolation, and residents lack access to services.
Woodland	Northeast and northwest areas have high poverty. COVID cases highest in areas of poverty. Seniors living on congregate communities disproportionately impacted by COVID. Need safe places to play and recreate that are heat protective. Residents experiencing homelessness, especially in downtown area. Lack of great space to exercise. Need to bring people back together and gather safely in COVID, increase community connectedness. Housing issues – need affordable housing. High Hispanic population. Childhood obesity rates are high.
Rural areas of county Guinda/ Ramsey/Brooks	Limited access to safe physical activity. Higher rates of poverty. Lower vaccinations rates, highest COVID burden. High rates of poverty. High rates of isolation. Transportation a barrier to access services. High rates of chronic disease like diabetes. Need for affordable and safe housing. Public transportation very limited. High rates of poverty. Need for increased emergency preparedness in the rural areas.

California Healthy Places Index

Figure 5 displays the California Healthy Places Index (HPI)[16] values for Yolo County. The HPI is an index based on 25 health-related measures for communities across California. Measures included in the HPI were selected based on their known relationship to life expectancy and other health outcomes. These values are combined into a final score representing the overall health and well-being of the community, which can then be used to compare the factors influencing health in different communities. Higher HPI index values are found in communities with a collection of factors that contribute to greater health, and lower HPI values are found in communities where these factors are less present.

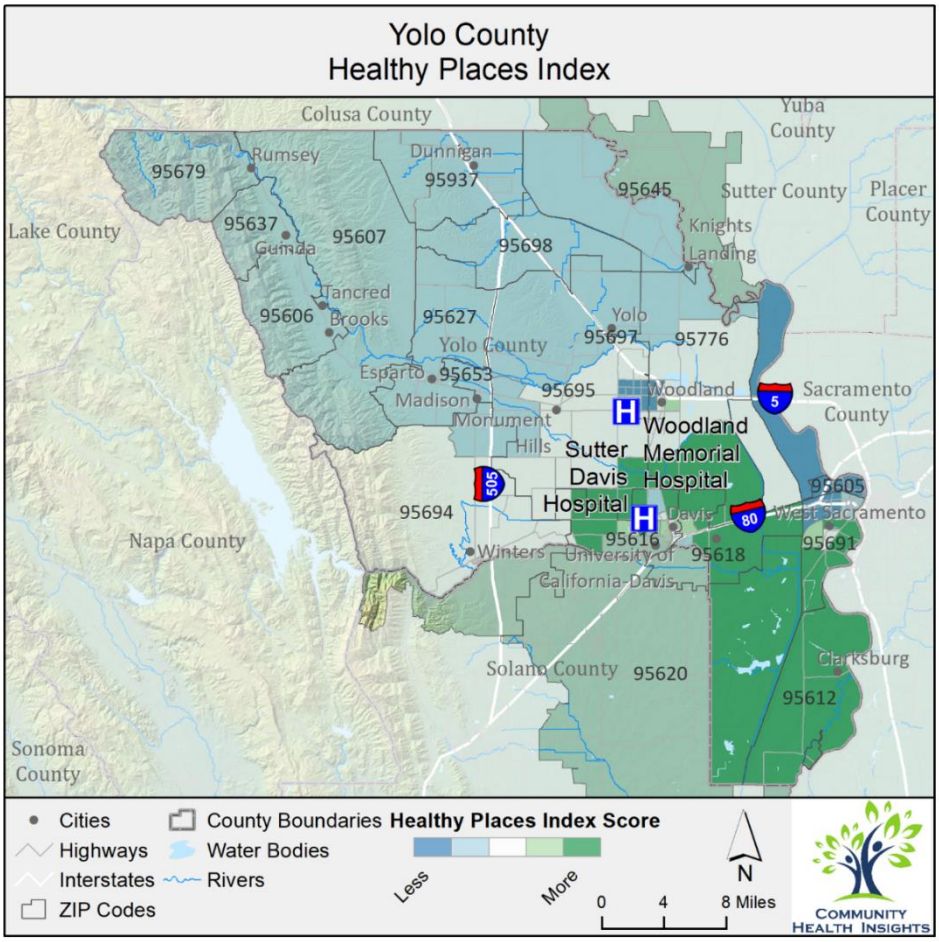


Figure 5: Healthy Places Index for Yolo County.

Areas with blue shading in Figure 5 have the lowest and second to lowest overall HPI scores, indicating a higher proportion of unhealthy factors associated with neighborhoods. There is likely to be a higher concentration of residents in these locations experiencing health disparities.

[16] Public Health Alliance of Southern California. 2021. The California Health Places Index (HPI): About. Retrieved from https://healthyplacesindex.org/about/.

Communities of Concern

Communities of Concern are geographic areas within the county that have the greatest concentration of poor health outcomes and are home to more medically underserved, low-income, and diverse populations at greater risk for poorer health. Communities of Concern are important to the overall CHNA methodology because, after the county is assessed more broadly, they allow for a focus on those portions of the county likely experiencing the greatest health disparities. Geographic Communities of Concern were identified using a combination of primary and secondary data sources. (Refer to the technical section for an in-depth description of how these are identified). Analysis of both primary and secondary data revealed 9 ZIP Codes that met the criteria to be classified as Communities of Concern. These are noted in Table 6, with the census population provided for each, and they are displayed in Figure 6.

Table 6: Identified Communities of Concern for Yolo County.

ZIP Code	Community\Area	Population
Primary Communities of Concern		
95605	West Sacramento	14,493
95691	West Sacramento	38,690
95695	Woodland	41,278
95776	Woodland	23,911
Secondary Communities of Concern		
95612	Clarksburg	1,321
95627	Esparto	3,802
95645	Knights Landing	1,881
95653	Madison	581
95937	Dunnigan	1,540
Total Population in Communities of Concern		*127,497*
Total Population in Yolo County		*217,352*
Percentage of Population in Communities of Concern*		*58.7%*

Source: 2019 American Community Survey 5-year estimates; U.S. Census Bureau.

*Populations in ZIP codes identified as Communities of Concern (some of which include population outside of the county) divided by total population for Yolo County.

Figure 6 displays the ZIP Codes highlighted in pink (primary) and blue (secondary) that are Communities of Concern in Yolo County.

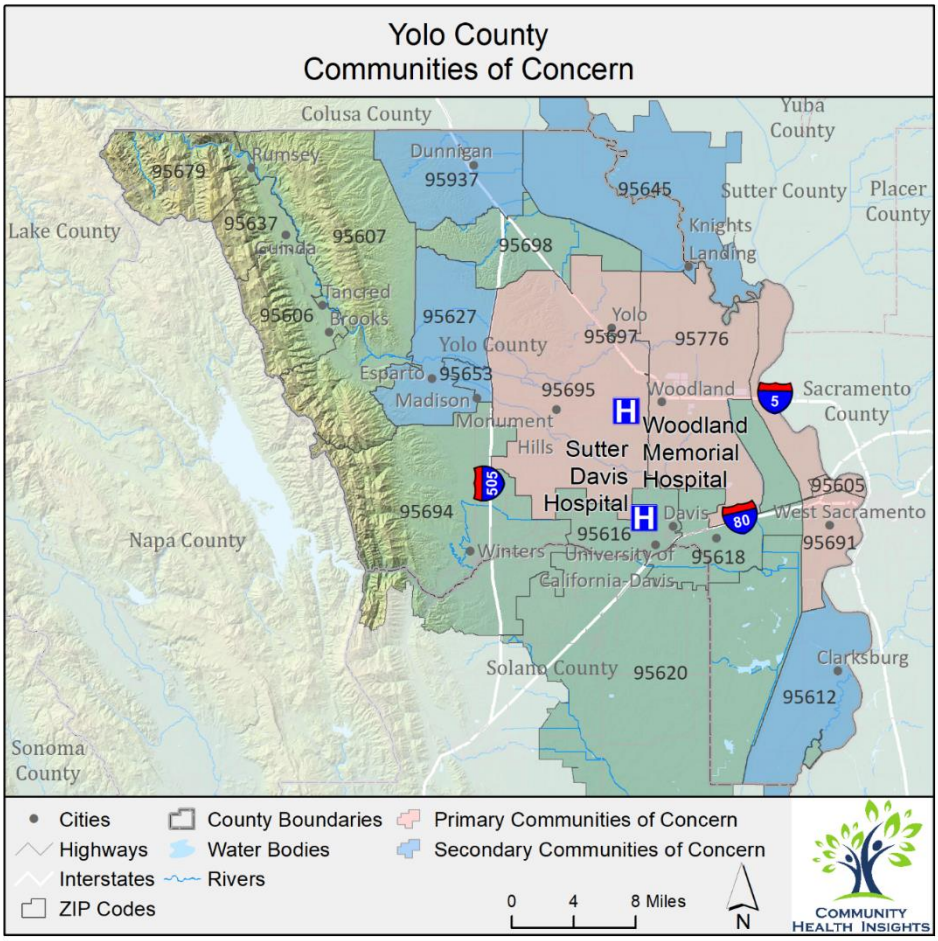


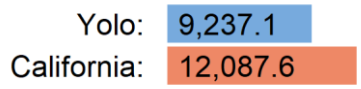
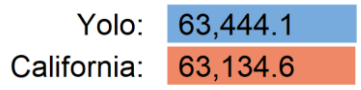
Figure 6: Yolo County Communities of Concern.

The Impact of COVID-19 on Health Needs

COVID-19 related health indicators for Yolo County are noted in Table 7.

Table 7: COVID-19-related rates for Yolo County.

Indicators	Description	Yolo	California	
COVID-19 Mortality	Number of deaths due to COVID-19 per 100,000 population.	118.2	185.1	Yolo: 118.2 California: 185.1
COVID-19 Case Fatality	Percentage of COVID-19 deaths per laboratory confirmed COVID-19 cases.	1.3%	1.5%	Yolo: 1.3% California: 1.5%

COVID-19 Cumulative Incidence	Number of laboratory confirmed COVID-19 cases per 100,000 population.	9,237.1	12,087.6	
COVID-19 Cumulative Full Vaccination Rate	Number of completed COVID-19 vaccinations per 100,000 population.	63,444.1	63,134.6	

Source: COVID19.CA.GOV. Retrieved November 17, 2021.

Indicators in Table 7 related to COVID-19 for Yolo County, compared to the state, show lower COVID-19 mortality, slightly lower case fatality rate due to COVID-19, lower cumulative incidence, and a higher COVID-19 full vaccination rate. Table 8 displays cases and testing percentages by race and ethnicity for Yolo County.

Table 8: COVID-19 inequities by race and ethnicity in Yolo County.

COVID-19	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	White
Percent of County Population	Percentage of population by group	0.6%	19.1%	2.6%	32.1%	42%
Percent COVID-19 Cases	Percentage of COVID-19 cases by race and ethnicity	~	17.3%	~	35.5%	41.5%
Percent testing COVID-19	Percentage of COVID-19 testing by race and ethnicity	~	22.6%	~	21.9%	51.4%
COVID-19 Cases per 100,000 population	Case rate of COVID-19 by race and ethnicity	~	3,057	~	3,735	3,336

Source: COVID19.CA.GOV. Retrieved November 17, 2021.
~ Data not shown because there were fewer than 20,000 people in this group.

Hispanics have the highest COVID-19 case rate per 100,000, a larger percent of cases relative to their percent of the population, and the lowest percent testing of any other group. Both Asians and Whites have higher percent of testing relative to their percent population in the county.

Key informants and focus group participants were asked how the COVID-19 pandemic had impacted the health needs they described during interviews. Service Provider Survey respondents were also asked to identify ways in which COVID-19 impacted health needs in the communities they served. A summary of their responses is shown in Table 9.

Table 9: The impacts of COVID-19 on health need as identified in primary data sources.

Key Informant and Focus Group Responses	Service Provider Survey Responses
- Fear of accessing care for both the acute and chronically ill. - Preventive and emergent health visits placed on hold due to fear of contagion. - Amplified mental health needs in the county. - Limits at receiving care due to lack of devices or tech literacy challenges. - Basic needs have gotten more pronounced (housing, food insecurity). - Many residents (farm workers) continued to work as essential workers during the shutdown. - Seniors were disproportionately affected – especially those in congregate living communities. - COVID-19 disproportionately affected the following groups in Yolo County: Latinos, seniors, homeless, migrant workers, previously isolated, marginalized. - Breastfeeding rates dropped, while lower birthweight babies were born in the county. - Vaccination rates in Latino migrant and Russian communities are low. - Chronic disease indicators have worsened for many – increased blood pressure, increased blood sugar. - Academic challenges of youth and young adults worsened. - Community and gun violence has increased in the pandemic. **Pandemic silver linings:** - New partnerships among organizations and Yolo Health and Human Services (HHS), and between organizations, were formed. - Vaccination distribution by Yolo HHS was efficient and well organized. - Local organizations developed creative ways for vaccine dissemination.	- Isolation is harming the mental health of community members. - Residents delayed healthcare to limit their exposure to the virus. - Residents encounter economic hardships from lost or reduced employment. - Youth no longer have ready access to the services they previously received at school (e.g., free/reduced lunch, mental and physical health services). - Residents in the community are being evicted from their homes.

The Yolo County Community Health Status survey (community survey) asked specific questions about the impact of COVID-19 on various life factors. Question 21 asked, "Have you received healthcare services or medical screenings in the past 12 months? (Routine check-up, blood pressure screening, mammogram, etc.)." Among respondents that indicated "no", 27.84% stated they did not receive healthcare services or medical screenings in the past 12 months due to COVID-19 exposure concerns.

Survey participants were also asked about the top three "negative impacts of the COVID-19 Pandemic on the overall health and wellbeing of the Yolo County community?" The most commonly mentioned negative impacts are as follows with the corresponding percent of the community survey sample selecting each item:

- Job loss or reduction in work hours (46.2%)
- Businesses closing (42.5%)
- Mental health issues (42.3%)
- Illness related to contracting COVID-19 (36.5%)

- Social isolation (30.9%)
- Schools closing (27.3%)
- Lack of childcare for working parents (21.8%)

Resources Potentially Available to Meet the Significant Health Needs

In all, 367 resources in the service area were identified in Yolo County that were potentially available to meet the identified significant health needs. These resources were provided by a total of 112 social service, nonprofit, and governmental organizations, agencies, and programs identified in the assessment. The identification method included starting with the list of resources from the 2019 Yolo County collaborative CHNA, verifying that the resources still existed, and then adding newly identified resources into the 2022 CHNA report. Examination of the resources revealed the following numbers of resources for each significant health need as shown in Table 10.

Table 10: Resources potentially available to meet significant health needs in priority order.

Significant Health Needs (in Priority Order)	Number of Resources
Access to Basic Needs Such as Housing, Jobs, and Food	76
Access to Mental/Behavioral Health and Substance Use Services	47
Injury and Disease Prevention and Management	19
Active Living and Healthy Eating	32
Access to Quality Primary Care Health Services	43
System Navigation	30
Access to Specialty and Extended Care	19
Increased Community Connections	48
Safe and Violence-Free Environment	37
Access to Functional Needs	11
Access to Dental Care and Preventive Services	5
Total Resources	**367**

For more specific examination of resources by significant health need and by geographic location, as well as the detailed method for identifying these, see the technical section.

Impact/Evaluation of Actions Taken by Hospital since 2019 CHNA

Regulations require that each hospital's CHNA report include: "an evaluation of the impact of any actions that were taken since the hospital facility finished conducting its immediately preceding CHNA to address the significant health needs identified in the hospital facility's prior CHNA(s)."[17]

Priority Health Need Addressed: Access to Mental, Behavioral and Substance Use Services	
Mental Health Crisis Prevention and Early Intervention	
Program Description	This partnership was developed by the hospital and is focused on building a continuum of care in the community for mental health care working with Suicide Prevention of Yolo County and Yolo Community Care Continuum which operates the Safe Harbor crisis residential treatment facility.
Fiscal Years Active	✓ FY 2019 ✓ FY 2020 ✓ FY 2021
Secondary Health Needs Addressed	✓ Access to Mental, Behavioral and Substance Use Services ✓ Injury and Disease Prevention and Management ❑ Access to Basic Needs, such as Housing, Jobs and Food ❑ Active Living and Healthy Eating ✓ Access to Quality Primary Care Health Services ❑ Access to Specialty and Extended Care ❑ Safe and Violence-Free Environment
Program Performance / Outcomes[1]	Across all three partners, 62 persons received services which included 25 crisis residential referrals to YCCC Safe Harbor. 90 attempts were made to follow up with the new Safe Harbor clients.
Dignity Health Contribution / Program Expense[2]	$52,000

Priority Health Need Addressed: Disease Prevention, Management and Treatment	
Congestive Heart Active Management Program (CHAMP)	
Program Description	CHAMP® establishes a relationship with patients who have heart failure after discharge from the hospital through regular phone interactions to support, educate and assist primary care physicians/cardiologists to manage this disease and monitoring of symptoms or complications.
Fiscal Years Active	✓ FY 2019 ✓ FY 2020 ✓ FY 2021
Secondary Health Needs Addressed	❑ Access to Mental, Behavioral and Substance Use Services ✓ Injury and Disease Prevention and Management ❑ Access to Basic Needs, such as Housing, Jobs and Food

[17] *Federal Register*, Vol. 79, No. 250, (Wednesday, December 31, 2014). Department of the Treasury, Internal Revenue Service.

	❑ Active Living and Healthy Eating ✓ Access to Quality Primary Care Health Services ✓ Access to Specialty and Extended Care ❑ Safe and Violence-Free Environment
Program Performance / Outcomes[1]	The total enrollment was 1,737 participants
Dignity Health Contribution / Program Expense[2]	$141,858
Healthier Living	
Program Description	The Healthier Living program allows participants to learn about and practice a wide variety of tools to help them become better self-managers of their ongoing health conditions. Workshops are open to anyone with a chronic health condition, as well as those who care for persons with chronic health conditions. They are offered at the community level in partnership with medical clinics and community partners to ensure the underserved have access to these peer led health education classes. Provided in both English and Spanish.
Fiscal Years Active	✓ FY 2019 ✓ FY 2020 ✓ FY 2021
Secondary Health Needs Addressed	❑ Access to Mental, Behavioral and Substance Use Services ✓ Injury and Disease Prevention and Management ❑ Access to Basic Needs, such as Housing, Jobs and Food ✓ Active Living and Healthy Eating ✓ Access to Quality Primary Care Health Services ❑ Access to Specialty and Extended Care ❑ Safe and Violence-Free Environment
Program Performance / Outcomes[1]	2,564 persons were served through community education and outreach on healthier living, chronic disease management and prevention of infection COVID-19.
Dignity Health Contribution / Program Expense[2]	$52,856

Priority Health Need Addressed: Access to Basic Needs, such as Housing, Jobs and Food	
Haven House	
Program Description	A partnership between Woodland Memorial, Sutter Davis, and the Yolo Community Care Continuum, Haven House is a medical respite transitional program. The program utilizes a four bed house and offers temporary shelter as well as linkage to supportive services for medically fragile homeless individuals upon discharge from the hospital.
Fiscal Years Active	❑ FY 2019 ❑ FY 2020 ✓ FY 2021

Secondary Health Needs Addressed	❑ Access to Mental, Behavioral and Substance Use Services ✓ Injury and Disease Prevention and Management ✓ Access to Basic Needs, such as Housing, Jobs and Food ❑ Active Living and Healthy Eating ✓ Access to Quality Primary Care Health Services ✓ Access to Specialty and Extended Care ✓ Safe and Violence-Free Environment
Program Performance / Outcomes[1]	50 persons served with a total of 282 bed nights, which otherwise would have been spent in the hospital.
Dignity Health Contribution / Program Expense[2]	$60,0000

Priority Health Need Addressed: Active Living and Healthy Eating	
Farmers Market	
Program Description	Working with multiple agencies, local farmer's and community partners, the hospital hosts a weekly farmers' market running June through the end of August. The market purposely establishes basic price points, ensuring the locally sourced foods are accessible, affordable and beneficial to both the local food economy, the community as a whole and those touched with food insecurities which includes CalFresh.
Fiscal Years Active	✓ FY 2019 ✓ FY 2020 ✓ FY 2021
Secondary Health Needs Addressed	❑ Access to Mental, Behavioral and Substance Use Services ✓ Injury and Disease Prevention and Management ✓ Access to Basic Needs, such as Housing, Jobs and Food ✓ Active Living and Healthy Eating ❑ Access to Quality Primary Care Health Services ❑ Access to Specialty and Extended Care ❑ Safe and Violence-Free Environment
Program Performance / Outcomes[1]	5,400 persons served
Dignity Health Contribution / Program Expense[2]	$3,260

Priority Health Need Addressed: Access to Quality Primary Care Health Services	
Patient Navigator Program	
Program Description	In partnership with community-based organization, Empower Yolo, The hospital to offers Emergency Department Navigation services. The focus will continue to be connecting individuals to primary care providers in the community and assisting in establishing a medical home and follow up care post emergency department visit. The navigators provide health education in both Spanish and English, create linkages to primary care, health insurance enrollment assistance, case management and community referrals.

Fiscal Years Active	✓ FY 2019 ✓ FY 2020 ✓ FY 2021
Secondary Health Needs Addressed	❑ Access to Mental, Behavioral and Substance Use Services ❑ Injury and Disease Prevention and Management ❑ Access to Basic Needs, such as Housing, Jobs and Food ✓ Active Living and Healthy Eating ✓ Access to Quality Primary Care Health Services ❑ Access to Specialty and Extended Care ❑ Safe and Violence-Free Environment
Program Performance / Outcomes[1]	1,297 individuals served and connected to a variety of community resources including primary care.
Dignity Health Contribution / Program Expense[2]	$173,600

Priority Health Need Addressed: Access to Specialty and Extended Care	
Yolo Adult Day Health Center (YADHC)	
Program Description	The hospital is the primary provider in Yolo County that addresses specialty health care and support needs of the elderly and disabled populations through the Adult Day Health Center. The Center offers an interdisciplinary program of medical, psycho-social and rehabilitation services for adults at high risk of needing a higher level of care due to health, functional and cognitive losses. The Center specializes in high touch chronic disease management with the added components of caregiver respite, transportation, nutrition, education, and socialization.
Fiscal Years Active	✓ FY 2019 ✓ FY 2020 ✓ FY 2021
Secondary Health Needs Addressed	❑ Access to Mental, Behavioral and Substance Use Services ✓ Injury and Disease Prevention and Management ✓ Access to Basic Needs, such as Housing, Jobs and Food ✓ Active Living and Healthy Eating ✓ Access to Quality Primary Care Health Services ✓ Access to Specialty and Extended Care ✓ Safe and Violence-Free Environment
Program Performance / Outcomes[1]	1,156 persons served
Dignity Health Contribution / Program Expense[2]	$1,190,152
Oncology Nurse Navigation	
Program Description	The Oncology Nurse Navigation program offers one-to-one support and guidance to patients diagnosed with cancer from the day of diagnosis onwards. The Oncology navigators provide interventions that address patient's immediate concerns and barriers to care such as difficulties with insurance, financial burden, lack of

	transportation and addressing the knowledge deficit of around their diagnosis and treatment options. The Navigation program also provide referrals for nutritional and psycho-social support as well hosting multiple cancer support groups across the region.
Fiscal Years Active	✓ FY 2019 ✓ FY 2020 ✓ FY 2021
Secondary Health Needs Addressed	✓ Access to Mental, Behavioral and Substance Use Services ✓ Injury and Disease Prevention and Management ❑ Access to Basic Needs, such as Housing, Jobs and Food ✓ Active Living and Healthy Eating ✓ Access to Quality Primary Care Health Services ✓ Access to Specialty and Extended Care ❑ Safe and Violence-Free Environment
Program Performance / Outcomes[1]	696 persons served
Dignity Health Contribution / Program Expense[2]	$18,559

1. All program outcomes and expenses are reflective of the timeframe (fiscal years) indicated by the boxes checked in the 'Fiscal Years Active' section of the table for each program.
2. Outcomes and expenses are also shared between the Dignity Health hospitals indicated by the boxes checked in the 'Active Hospitals' section of the table for each program.

Collaboration

During FY19-FY21, Woodland Memorial Hospital utilized collaborative strategies to assess current strengths, weaknesses and gaps, and engaged non-traditional partners in community health programs to increase access to expanded services and increase the continuum of care beyond hospital walls for its patients and community it serves.

Collaborative programs and partnerships across these various initiatives include:

- Yolo Food Bank
- RISE, Inc.
- Nutritional Education and Counseling
- Commit2Fit
- Inpatient Mental Health Services
- Cristo Rey
- CommuniCare Capacity Building
- Yolo Crisis Nursery
- Multiple Sclerosis Support Group
- Migrant Center Visits
- Human Trafficking Response Program
- Baby & Me
- Federally Qualified Health Center Capacity Building

Community Grants

The theme for Dignity Health's Community Grants program focuses on collaboration with an emphasis on responding to significant health needs identified in the CHNA. The goal of the program is to develop strategic partnerships between community-based organizations that link services directly to Dignity Health hospitals; leveraging resources that address priority health issues, and utilize creative strategies that have a direct, positive and lasting impact on the health of disadvantaged individuals and families in our community.

To be eligible for funding, organizations must work in collaboration with a minimum of 3 community partners. Program/Project responds to one or more of the following priority health needs in Yolo County:

- Access to Behavioral Health Services: Includes access to mental health and substance abuse prevention and treatment services.
- Active Living and Healthy Eating: Affects health behaviors (e.g., fruit and vegetable consumption), associated health outcomes (e.g., diabetes) and aspects of the physical environment/living conditions (e.g., food deserts).
- Disease Prevention, Management and Treatment: Includes disease prevention and/or management programs that improve health status.

In FY 2019 through FY 2021, the Woodland Memorial Hospital awarded 7 grants totaling $287,194. The table below highlights the grantees.

Community Grants					
Lead Grant Recipient	**Priority Health Need(s) Addressed**	**Project Name**	**Fiscal Years Funded**		
			FY19	FY20	FY21
Yolo Hospice	Access to Behavioral Health Services; Active Living and Healthy Eating; Disease Prevention, Management and Treatment	Community-Based Palliative Care for Vulnerable Populations Yolocare	$54,088	$56,800	
Yolo Community Care Continuum	Access to Behavioral Health Services; Active Living and Healthy Eating; Disease Prevention, Management and Treatment	Enhanced Mental Health Crisis Services and Follow-up	$54,088		
Cache Creek Conservancy	Access to Behavioral Health Services; Active Living and Healthy Eating; Disease Prevention, Management and Treatment	Yolo Healthy Parks, Healthy People		$30,085	
Yolo Crisis Nursery	Access to Behavioral Health Services; Disease Prevention, Management and Treatment	Family Engagement and Wellness Initiative			$40,600

Mercy Coalition of West Sacramento	Access to Behavioral Health Services; Active Living and Healthy Eating; Disease Prevention, Management and Treatment	Mercy Resource Station			$46,533
Time of Change	Access to Behavioral Health Services; Disease Prevention, Management and Treatment	Coronavirus Pandemic Community Benefit Support Grant			$5,000
Grand Total			**$108,176**	**$86,885**	**$92,133**

Conclusion

This joint CHNA/CHA report details the needs of the Yolo County community as a part of a successful collaborative partnership between Sutter Davis Hospital, Woodland Memorial Hospital, and Yolo County Health and Human Services Community Health Branch. Community Health Assessments play an important role in helping community partners determine where to focus community benefit and health improvement efforts, including targeting efforts in geographic locations and on specific populations experiencing inequities leading to health disparities. Data in this report can help nonprofit hospitals, local health departments, and community service providers work in collaboration to engage in meaningful community health improvement efforts.